(4) Compensation of all administrative staff who perform no duties which are related to the nursing facility or its home office and who are neither officers nor owners of the nursing facilities or its home office.

(B) Indirect Cost:

(1) Capital, rental, maintenance supplies/repairs, and utility costs which are normally or frequently a part of a nursing facility. This would include, for example, kitchen and laundry facilities.

(2) Home office costs except for salary and fringe benefits of Personnel, Accounting and Data Processing staff which are allocated by acceptable methods are direct costs when the work performed is specific to the related organization that provides a direct care service or product to the provider.

(3) Compensation of all administrative staff who perform any duties for the nursing facility or its home office.

(4) All compensation of all officers and owners of the nursing facility or its home office, or parent corporation.

The related organization must file a Medicaid Cost Statement (DMA-4083) identifying their costs, adjustments to costs, allocation of costs, equity capital, adjustments to equity capital, and allocations of equity capital along with the nursing facilities cost report. A home office, or parent company, will be recognized as a related organization. Auditable records to support these costs must be made available to staff of the Division of Medical Assistance and its designated contract auditors. Undocumented costs will be disallowed.

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It is the nursing facility's responsibility to demonstrate by convincing evidence to the satisfaction of the Division of Medical Assistance that the criteria in the Provider Reimbursement Manual, Section 1010, has been met in order to be recognized as an exception to the related organization principle.

When a related organization is deemed an exception; (1) reasonable charges by the related organization to the nursing facility are recognized as allowable costs; (2) receivables/payables from/to the nursing facility and related organization deemed an exception are not adjusted from the nursing facility's balance sheet in computing equity capital.

(e) Auditing and Settlement. All filed cost reports must be desk audited and interim reimbursement settlements made in accordance with the provision of this plan. This settlement is issued within 180 days of the date the cost report was filed or within 180 days of December 31 of the fiscal year to which the report applies, whichever is later. The state may elect to perform field audits on any filed cost reports within three years of the date of filing and issue a final settlement on a time schedule that conforms to Federal law and regulation. If the state decides not to field audit a facility a final reimbursement notice may be issued based on the desk audited settlement. The state may reopen and field audit any cost report after the final settlement notice to comply with Federal law and regulation or to enforce laws and regulations prohibiting abuse of the Medicaid Program and particularly the provisions of this reimbursement plan.

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.0105 RETURN ON EQUITY

(a) In addition to the prospective rates described in Rule .0104, proprietary providers are eligible to receive a return on equity capital payment each year.

(b) Effective October 1, 1993, the rate of return shall equal the lower of 11.875 percent or the appropriate interest rate for the cost report period as prepared and published by the Office of the Actuary, Health Care Financing Administration for Proprietary Skilled Nursing Facilities.

(c) The rate is calculated on a capital base determined to be the total assets of the provider, its related home office, if any, that are required to provide nursing care less related liabilities. The value of the fixed assets is the historical cost less accumulated depreciation of buildings and improvements, all equipment, and vehicles. Leases and direct capitalized expenditures are not to be included in this calculation. Working capital shall not be recognized beyond a level equal to 16.5 percent of the facility's total annual cost.

(d) Liabilities must include all liabilities related to the assets of the facility regardless of nature or named payor. If the state determines that the liability has been incurred to acquire an asset named on the balance sheet that liability shall be counted.

(e) Providers have a positive obligation to identify all liabilities that may bear upon reported assets. Failure to disclose a liability later determined to be related to a reported asset shall result in a suspension of Return on Equity payments for the year(s) in which the failure occurred and up to five additional years at the discretion of the state. If the state determines that the provider's failure to report a related liability was an unintentional oversight, the potential five year penalty shall not be applied.

(f) The value of assets and related capital indebtedness when asset ownership changes shall be established in conformance with the provisions of Rule .0104(c).

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.0106 RECONSIDERATION REVIEWS

(a) Providers may either accept agency reimbursement determinations or request a reconsideration review in accordance with the procedures set forth in 10 NCAC 26K.

(b) Indirect rates shall not be adjusted on reconsideration review.

(c) A direct rate may be adjusted on reconsideration review if a provider can establish to the satisfaction of the state agency that such an adjustment is necessary to protect the health and safety of its patients and to sustain its financial viability. A facility is considered to be financially viable, and therefore not eligible for a rate adjustment, if its total Medicaid rate payments and return on equity exceeded its total Medicaid cost as reported in the most recent twelve month cost report. Providers are expected to utilize all available funds to provide the services that their patients need. Once a provider has reported a loss for a twelve month period beginning October 1 and ending September 30, a direct rate adjustment can then be negotiated for the following year at a level no greater than what is absolutely necessary for patient care and for the financial viability of the facility. The adjusted rate cannot exceed the applicable maximum direct rate as established by Rule .0102(b)(4) and (5).

(d) Direct rates may also be adjusted without regard to the provisions of .0106(c) of this Section for the following reasons:

(1) to correct erroneous data in the rate base;

(2) to accommodate any changes in the minimum standards or minimum levels of resources required in the provision of patient care that are mandated by state or federal laws or regulation;

(3) to maintain services at levels commensurate with any rate adjustments that are allowed between the base year and the year in which the rates derived from that base year are first effective.

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(e) Adjustments to reimbursement settlements shall be made on the basis of the reimbursement principles set forth in this plan or incorporated here by reference (See Rule .0104(e)).

.0107 PAYMENT ASSURANCE

(a) The state will pay each provider of nursing care services, who furnishes the services in accordance with the requirements of the State Plan and the Participation agreement, the amount determined under the plan. In addition, Nursing Facilities must be enrolled in the Title XVIII Program. However, State-operated nursing facilities are not required to be enrolled in the Medicare program.

(b) In no case shall the payment rate for services provided under the plan exceed the facility's customary charges to the general public for such services.

(c) The payment methods and standards set forth herein are designed to enlist the participation of any provider who operates a facility both economically and efficiently. Participation in the program shall be limited to providers of service who accept, as payment in full, the amounts paid in accordance with the State Plan. This reimbursement plan is effective upon approval of the State Plan for Medical Assistance.

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(d) In all circumstances involving third party payment, Medicaid is the payor of last resort. No payment will be made for a Medicaid recipient who is also eligible for Medicare, Part A, for the first 20 days of care rendered to skilled nursing patients. Medicaid payments for coinsurance for such patients will be made for the subsequent 21st through the 100th day of care. The Division of Medical Assistance will pay an amount for each day of Medicare Part A inpatient coinsurance, the total of which will equal the facility's Medicaid per diem rate less any Medicare Part A payment, but no more than the Medicare coinsurance amount. In the case of ancillary services providers are obligated to:

(1) maintain detailed records or charges for all patients;
(2) bill the appropriate Medicare Part B carrier for all services provided to Medicaid patients that may be covered under that program; and
(3) allocate an appropriate amount of ancillary costs, based on these charge records adjusted to reflect Medicare denials of coverage, to Medicare Part B in the annual cost report. For failure to comply with this requirement, the state may charge a penalty of up to 5 percent of a provider's indirect patient care rate for each day of care that is provided during the fiscal year in which the failure occurs. This penalty shall not be considered an allowable cost for cost reporting purposes.
(4) properly bill Medicare or other third-party payors or have disallowance of any related cost claimed as Medicaid cost.

(e) The state may withhold payments to providers under the following circumstances:

(1) If the state has a reasonable expectation that the provider will not expend its direct rate for reasonable and allowable direct patient care costs, the state may, at its discretion, withhold a portion of each payment so as to avoid a large amount due back to the state upon reimbursement settlement pursuant to the provisions of Paragraph .0104(e) of this Section.

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(2) Upon provider termination the state may withhold a sum of money from provider payments that it reasonably expects will be due when final reimbursement settlements for all previous periods, including the period in which the termination occurred, are completed.
(3) Upon determination of any sum due the Medicaid Program or upon instruction from a legally authorized agent of State or Federal Government, the state may withhold sums to meet the obligations identified.
(4) The state may arrange repayment schedules within the limits set forth in federal regulations in lieu of withholding funds.
(5) The state may charge reasonable interest on over-payments from the date that the overpayment occurred.
(6) The State may withhold up to twenty (20) percent per month of a provider's payment for failure to file a timely cost report. These funds will be released to the provider after a cost report is acceptably filed. The provider will experience delayed payment while the check is routed to the State and split for the amount withheld.

.0108 REIMBURSEMENT METHODS FOR STATE-OPERATED FACILITIES

(a) A certified State-operated nursing facility is reimbursed for the reasonable costs that are necessary to efficiently meet the needs of its patients and to comply with federal and state laws and regulations. The costs are determined in accordance with Sections .0103 and .0104 except that annual cost reports are required for the fiscal year beginning on July 1 and ending on the following June 30 and must be submitted to the Division of Medical Assistance on or before the September 30 that immediately follows the June 30 year end. Payments will be suspended if reports are not filed. The Division of Medical Assistance may extend the deadline for filing the report if in its view good cause exists for the delay. The Medicare principles for the reimbursement of skilled nursing facilities will be utilized for the cost principles that are not specifically addressed in the State Plan.

(b) A per diem rate based on the provider's estimated annual cost divided by patient days will be used to make interim payments. A desk audit and a tentative settlement will be performed on each annual cost report to determine the amount of Medicaid reasonable cost and the amount of interim payments received by the provider.

(c) Any payments in excess of costs will be refunded to the Division. Any costs in excess of payments will be paid to the provider. An annual field audit will be performed by a qualified independent auditor to determine the final settlement amounts.

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The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.